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Original Articles

SOME POINTS IN THE PATHOLOGY OF APPENDICITIS, WITH SPECIMENS.*

BY JOHN YOUNG BROWN, M.D., St. Louis.

THE first specimen which I have here was removed from a case referred to me by Dr. Williamson, of Cabanne. A young boy, 18 years old, came to the doctor's office on the day that I saw him, suffering with quite an acute abdominal pain. Prior to this date he gave a history of having had similar attacks of this character. I saw the patient in the afternoon with the doctor. His pulse was about 86 and his temperature about 99°. The appendix could be very distinctly palpated. The pain over the site of the appendix was very acute. I advised an immediate operation, and he was taken to the Baptist Sanitarium and I operated on him that night. The point that I want to bring out in this case is the inability of either the practitioner or surgeon to tell the pathologic conditions that are going on in and about the appendix from the symptoms. This boy went on the table with a pulse that was nearly normal and a very slight rise of temperature. I opened the abdomen and found a densely adherent appendix with an abscess in the distal end. I believe that we should deal radically with these cases, and by radically I mean we should break up the adhesions and remove the appendix in every case. I have never seen a case where this could not be done. The more I do this character of work the less respect I have for pus. I believe, if you will, as Morris suggests, blow out this pus with peroxide of hydrogen, then wash out with a saline solution, the peritoneum with proper purgation will take care of a good deal of it. I never attempt to pack an abscess cavity with gauze, but endeavor to make a clean-cut enucleation and to remove the appendix in all cases. In cases of this character where the abscess is in the distal end of the appendix, there is a method of dealing with such cases which I do not think has been sufficiently emphasized, and that is the method in which the stump is entirely removed. The two usual methods of dealing with the stump are the inversion method and the buried suture method—the cuffing of the peritoneum, tying off the sound tube, then bringing this cuff over. Some years ago Price suggested the propriety of doing away entirely with the stump, and instead of having a buried ligature there cut it out of the cecum and stitch it up with a double row of Lembert's sutures, just as you would a gun-shot wound. I have had one case that was fatal following the buried stump method, where, after the removal of the gangrenous appendix, the gangrene extended and there was subsequent perforation with diffuse peritonitis and death. By this simple precedure of lifting out the cecum, and while an assistant holds the appendix, clipping it right at the head of the cecum, we do away with the buried sinus and can make a perfectly clean operation, and the results are ideal. Of course there are a great many cases where there is a wide area of ulceration and this method is not feasible, but in the large majority of the mild cases it can be resorted to. I do it almost exclusively, with a great deal of satisfaction, and I always feel safer with the stump entirely done away with.

Here is an appendix from a case that was referred to me by Dr. Palmer. This was a young man who gave no history of any previous attack. I saw him one afternoon with an acute appendicitis; that is, there was local evidence of acute appendicitis, and I operated on him at the Baptist Sanitarium. I found the appendix perforated at the proximal end. In this case you could not have told from the local condition, either the pulse or temperature, the extent of the involvement. This specimen, I think, is quite an interesting one.

The next specimen is an appendix that I removed day before yesterday. It is a very beautiful specimen of acute appendicitis with ulceration of the appendix, which shows very nicely. You can see here the area of ulceration. I saw the patient in the morning with Dr. Love. The patient had had intestinal disturbances for a year or more, but no well-marked, pronounced attack of appendicitis. His symptoms were acute; he had high pulse and a high temperature. I took the appendix out through an inch and a half incision, treating the stump by the method described, closed without drainage.

One of the most important features to me about appendicitis is to urge an early operation. I firmly

*Read before the St. Louis Medical Society of Missouri October 7, 1899.

believe that there never was a case lost which could not have been saved if it had been seen at the proper time by a competent surgeon. There is nothing to be gained in these cases by delay. The concensus of surgical opinion is that we cannot tell which cases are going on to recovery; none of them recover—that is, they rarely recover if the appendix is left behind; the condition that we see there frequently ends in chronic appendicitis, and the more I see of this work, and I have done a great deal of it, the less faith I have in my ability to tell which cases will go on to an interval. Of course, if we could operate on all these cases in the interval, it would be the proper time to deal with them surgically, but we cannot tell which case is going to reach an interval, and there is a great difference where you can operate early and make a small incision and a clean enucleation and close it without drainage. These specimens here illustrate the different varieties of the disease. This is a specimen I removed from a case that I saw with Dr. Love and Dr. Gettys. A young fellow about 18 years old, who had a diffuse general peritonitis. By a diffuse general peritonitis I mean from a surgical standpoint; of course, none of those acute general peritonitis cases get well without operation; they all die; that is, where the peritoneum is involved entirely. I saw this young man one afternoon about four o'clock and operated on him that night at 10 o'clock. He went to the table with a pulse of 130 and a temperature of 104½°. There was liquefied lymph loose in the abdominal cavity, the appendix was completely gangrenous and sloughed and rotten; gangrenous omentum was found. This case was drained and he made a very clean, nice recovery.

Here is another specimen that illustrates the same character of inflammation. This case was sent to me by Dr. Strauss. I operated at the Mullanphy Hospital four weeks ago and found diffuse peritonitis present. The man was a syphilitic; he gave a history of having been treated for an attack of typhoid fever some five months before. His general condition was very poor and it was a most unfavorable case. He was drained and his recovery was uneventful.

There is one point in regard to the treatment of appendicitis upon which I want to lay especial emphasis, and that is on the character of drainage. I remember reading some time ago an article by a surgeon who went out of his way to criticise a very prominent surgeon of this city, who, in an article on this subject, has attributed some deaths that he had had from appendicitis to the iodoform gauze packing. I do not think I misstate it when I say that it has been conclusively proven that iodoform gauze should not be tucked into the peritoneal cavity. I do not think there is any question that it is responsible for the death of a very large number of patients. For instance, you open the abdomen by a wide incision, and after enucleating the appendix, you pack gauze in there, a strip in this direction, and a strip in that direction, and a strip in the other direction. You really accomplish nothing by this method of drainage, but only aggravate the condition. In 24 hours you have an exudate thrown out in the meshes of the gauze, and if the patient survives the treatment an anesthetic is necessary when the drainage is removed. It accomplishes no more than the wick drain, which has been proposed by Morris; it is a very small strip of gauze surrounded by gutta percha tissue, passed down to the seat to be drained. The gauze can be left in and when it is removed it comes out without apparent trouble or pain; but the plan of placing gauze in different directions is one that I cannot condemn too strongly. I have had to deal with quite a number of these cases where I felt that the evil results that were obtained in the cases were due entirely to the character of the drainage. It is absolutely impossible to make a complete irrigation of the peritoneal cavity under these circumstances. If the appendix is removed, as it should be in all cases, it should be completely removed, and to accomplish this it is necessary to break up all adhesions. The idea of opening an abscess and perhaps leaving behind two other abscesses is ridiculous; it is bad surgery and incomplete surgery, and a great many deaths result from the failure on the part of the surgeon to break up adhesions, and remove the cause as well as the effects of the disease. If the pus is properly blown out the peritoneum will take care of itself. These are things that can be demonstrated practically. The character of closure that I have been in the habit of making, and which I have had no occasion to change, is the through and through closure with the silk-worm gut. Some months ago I read a paper before this society on the through and through closure. The more I see of that method the more I realize that there are very few men who understand the proper method of making a through and through closure. If we would operate on all these cases and be sure of the buried material that is used in closing them, we might use the catgut and the kangaroo tendon, but my experience with the catgut and kangaroo tendon has not been favorable at all. In making this closure the incision should be as small as possible, and we should utilize what is called the guy line (Morris); put this through the muscle, peritoneum, and fascia, and then when the closure is to be made you can pull on this guy line, and then, retracting the skin far back, you go through the body of the muscle and peritoneum, and thus when you close you get a perfect approximation from below upwards. At the end of seven days you can remove the stitches without any fear of suppuration from infected buried material. This is applicable in small incisions, of course; if you have a large incision and are sure of

your material I think there is no question that the deep sutures are better than the through and through. But in a median closure I have never seen any method that equalled the proper application of the silk-worm gut by the through and through method.

This specimen that I have here is one of unusual interest. This I removed at the Baptist Sanitarium from an old lady 63 years old. When I saw the patient I obtained the following history: Three months before she came into my hands she had what apparently was an acute attack of appendicitis. Up to that time she had been perfectly well, and since the date of this acute attack her condition was chronic. When I saw her I found a mass about the cecum, perhaps as large as two fists. I advocated an operation, to which she consented, and I found on opening the abdomen this mass adherent to the parietal peritoneum with the cecum densely bound down. The tissues were so matted together that there were no land-marks present. I began the enucleation and got my land-marks from this tube, which is the appendix buried in this mass of exudate. This I traced down to the cecum, enucleated a great deal of tissue that we see here, and cut the appendix right out at the head of the cecum and closed with drainage. She had an abdominal wall that was perhaps three inches thick. There were no evidences of malignancy except the evidences that we had in the specimen. Of course I at once suspected the condition was malignant. Since the operation she has gained in flesh and is now apparently well. I have a report here from the pathologist, in which he says that the specimen is an adeno-carcinoma and undergoing cystic degeneration. I hope very much on her account that the diagnosis is incorrect, but I am a little fearful that the report is true.

FURTHER OBSERVATIONS ON THE TREATMENT OF THE ABDOMINAL VISCERA THROUGH THE COLON.

By FENTON B. TURCK, M.D., Chicago, Ill.

IN a previous communication it was shown that small quantities of hot water (55 C.) introduced into the rectum produced a marked effect on the heart and general circulation and especially on the abdominal organs. From these results it was evident that hot water introduced, at the temperature mentioned, into the colon, had a greatly beneficial effect upon the abdominal viscera. Air hot or cold forced through a double tube into the colon and allowed to escape also acts, not only as a powerful stimulant to the abdominal viscera, but also as a species of pneumatic gymnastics of the colon. In the introduction of hot water into the colon, the following technique is adopted: The patient is placed in a dorsal position upon a table specially devised for the purpose, which is so adjusted that the hips may be raised or lowered to any desired angle without discomfort. The solution employed is usually a 9 per cent. normal salt solution, when therapeutic effects of heat and cold are desired. For other purposes mild antiseptic and medicated solutions may be employed. A soft rubber tube, either single or double, with end and side openings, is introduced into the rectum as far as the sigmoid flexure. At first, 200 to 300 c.c. of water, at a temperature of 50° C., is introduced. This is allowed to return through a tube into a conveniently placed receptacle and the precedure repeated. Every time the water is introduced its temperature is gradually raised until it reaches 55° C.; in all, from 3 to 6 litres are needed. The patient is then allowed to evacuate the bowels; after which he receives similar short treatment with water cooled 2° C. or 5° C. The amount of water introduced and withdrawn and the duration of the treatment depend upon the character of the case.

For continuous irrigation my double recurrent tube or needle douche has answered the purpose best in the hands of gastro-enterologists like Herschell, Treves, Gillespie and others. By continuous irrigation a somewhat different action is obtainable from that already referred to. It is indicated in impaction, acute gastro-enteritis, and during the early stages of appendicitis. A strict observance of technique judiciously varied in each case gives the best results.

The mucous membrane of the colon, like that of the throat, seems to be insensible to comparatively high temperature. The sensations within the colon, as to heat or cold, are not very definite. This may in part be due to the fact that the colon sensation has been so specialized, as to fecal pressure, as to lose its heat and cold reaction. That the treatment through the colon influences not only the general circulation, but also stimulates the nerve actions of the abdominal viscera, and even the cerebral and spinal blood pressure has long been known. The principle on which stimulant enemata have been employed in opium coma and allied conditions is significant evidence of this. The ano-genital center is notoriously the last to be affected in coma. Numerous instances have been reported where death from opium coma and anesthesia have been prevented by its stimulation. Furthermore, stimulation of the ganglia in the walls of the intestines cannot fail to produce effect on the spinal and cerebral centers. The increased action of kidneys, liver and other organs, after the employment of colonic means, is evidence in this direction. This is furthermore shown by the fact that favorable results depend, not upon the amount of water introduced, but upon the reaction between heat and cold. Large quantities of water introduced at one time are detrimental. Small quantities frequently repeated have markedly beneficial effects.

In colonic treatment by water or air, single or double recurrent tubes may be employed, according to the nature of the case. A tube with a single opening at the end is useless, however, for colonic lavage. One designed by me consists of a rubber tube (1 meter long, with a calibre of 23 A or 35 F), tapered at the end to an opening with beveled edges. On either side are four small perforations opposite to each other in a row. Above this is a large side opening with edges so sunken as to prevent irritation in introducing the tube. The distance from the end of the tube to the uppermost opening is one and three-quarter inches. This tube insures rapid return of the water injected, and there is no danger of the suction of mucous membrane by siphonage. There is thus less danger of traumatism and of closure of the end of the tube by the mucous membrane or feces. This tube ensures a more equable distribution of the fluid introduced, and is therefore of special value in topical applications or in introduction of food. The double recurrent tube, or "needle douche," previously described, will be found of especial value when prolonged irrigation or lavage is desired. It has been found particularly useful in obstruction, from whatever cause, by Herschell and others. For the same reason it is of value in colon atony, or where hot or cold water is needed as a spray or needle douche. In some cases a tube capable of passing the sigmoid flexure may be needed. Most tubes now made pass only to this flexure, but not beyond. The stiff tubes press upon and so bulge the walls as to give the false impression that the tube has passed through the flexure. The flexible tubes coil up, and produce the same impression. My colonic sound and irrigator enables the physician to pass around the colon, even as far as the cecum. It consists of a double curved metallic tube, about 16 inches in length, so made as to be passed through the sigmoid flexure. The tube not only serves as a channel for the return of fluids injected, but also as a sheath for the introduction of a flexible hollow metallic cable. The distal end of the cable is surmounted by an olive-shaped perforated head. This serves as a guide for passing the sound. As the cable is hollow, it may be employed for colonic distention. This, if secured during the passage of the sound, will ensure further introduction. The position of the cable tip may be determined by palpation, especially if the cable be rotated. Since the cable is metallic, it can be employed as an electrode. Food, by this instrument, may be distributed over a wide area. Great objection frequently exists to the introduction of water, especially hot water, into the colon. The hot water produces depression, and even collapse at times. Warm water is particularly objectionable in this particular. Atony of the bowels from this cause, moreover, is very frequent. Distention of the bowels with water, subsequently withdrawn, would be of value in bowel gymnastics were it not for the fact that since the water is slow to return, and is not compressible, it causes undue distention.

In treatment of the colon the object is: first, when atony exists, to secure heat; second, distention; third, contraction, and peristalsis producing gymnastic exercise. If heat be desired, the air can be heated by passing it from a compressed-air tank through a bottle of water heated to the required temperature before passing it into the colon. The method of treatment is useful in atony of the bowels, whether it exists alone or with obstruction of impaction. Compressed air is used with a double tube introduced into the colon. When the colon is distended, air is allowed to escape through the outlet tube. Air at 55° C. reaches as far as the colon. Nebulization of the colon may be employed, any of the nebulizing mixtures adapted to the colon being used.

PROGRESS IN RECTAL AND ANAL SURGERY.

By SAMUEL G. GANT, M.D., of New York.
Lecturer on Anal and Rectal Surgery, New York Post Graduate School of Medicine.

NEW OPERATION FOR HEMORRHOIDS.—Dr. Sims (*Maryland Medical Journal*, XXXIX., p. 531), after criticising the older methods of operating for hemorrhoids, describes his methods as follows:

1. Thoroughly prepare the patient for operation.

2. Then with the fingers divulse the sphincters in every direction.

3. Next each tumor is seized, pulled down and held by an assistant.

4. With a scalpel the mucous membrane is then cut around through the base of the pile and a silk ligature applied, including all blood-vessels and connective tissues.

5. The tumor is then excised close to the ligature and the cut edges of the mucosa joined by continuous suture. If it is a very large pile, a double thread is passed through, and it is ligated in two sections.

6. External hemorrhoids are treated in the same way unless they are small and indurated, then they are cut off, bleeding is arrested, and the edges of the wound brought together with interrupted sutures of silk. The advantages claimed for this operation are:

a. By leaving only closed wounds the danger of infection is greatly diminished.

b. Recovery is uninterrupted and speedy.

c. The danger of hemorrhage is lessened.

d. Suffering is less after this than other operations for hemorrhoids.

PROSTATIC IRRITATION RELIEVED BY HEMORRHOIDAL OPERATIONS.—By Dr. Jelks (Transactions Medical Society of Tennessee, 1898, p. 163).

The author reports three unusual cases where all the annoying symptoms of prostatic enlargement im-

mediately disappeared after the removal of large inflamed hemorrhoids by the ligature. He is not aware of the extent to which this operation reduces the size of the prostate in a given case, if at all. He believes, however, that in a certain number benefit more or less permanent will be derived. At first there is irritation, next inflammation, and finally enlargement of the prostate gland as a sequence of rectal disease. The cause is to be found in the intimate relation of the blood-vessels, nerves and muscles of the rectum, prostate, urethra and bladder.

CRITICISM OF WHITEHEAD'S OPERATION FOR HEMORRHOIDS.—By Samuel G. Gant (Vol. XX., *Kansas City Index-Lancet*).

Finally, in summarizing, the writer says:

1. It is not suited for ordinary or bad cases of piles.

2. It is difficult and bloody.

3. Patients are detained in bed from six to fifteen days longer than after the clamp and cautery or ligature operations.

4. Owing to tension on the sutures, post-operative pains are severe and may continue for several days.

5. Infection is frequent, and terminates in stitch and deep abscess and fistula.

6. Because of non-union ulceration, stricture and pruritus are common sequelæ.

7. The portion of the bowel between the anus and the retracted gut loses its sensitiveness, and there is also an absence of the normal secretions.

8. The nervous and mental state of these sufferers is pitiable to behold; they may contract the morphin habit; others turn up as chronic invalids in some sanitarium or asylum.

FISTULA IN ANO.—(*Dominion Med. Month.*, XI., p. 194.)

In a very practical article, Dr. J. W. Shaw lays great stress on the fact that it is not only important to prevent an anal abscess becoming a fistula, but it is equally important after fistulous passages have formed to treat them radically before their parieties and internal linings become perfectly organized. He says in early childhood it is remarkable how fistulous tracts get well by the mildest measures, as rest, simple dressings, diet and laxatives. But in those cases in adults where the soft parts become involved, attended with deep burrows and sinuses, and have more than one external opening, the only treatment is the ligature and the knife.

LUMBAR COLOTOMY.—(*London Lancet*, p. 1747.)

The late Lawson Tait, in a forcible article on lumbar colotomy, says:

There came a boom on behalf of inguinal colotomy which was useless, and has proved disappointing, so far as I can learn. Personally, I never gave any countenance to the inguinal method save in one case, where I had abundant reason to regret it. I have had every reason to be perfectly satisfied with the older operation; so far as my own results were concerned, there were advantages in favor as against the operation in the groin, which seemed to me convincing, viz.:

a. There were cases where the obstruction was not relieved.

b. Cases where the disease advanced into and above the opening, which were not so affected following the lumbar method.

c. Eversion of the gut has been far more frequent and extensive than it ever is after the older operation.

d. The efficiency of the opening in preventing leakage is more satisfactory after lumbar than inguinal colotomy.

PRELIMINARY COLOSTOMY FOLLOWED BY A KRASKE OPERATION AND THE CLOSURE OF THE LOWER END OF THE RECTUM.—By W. W. Keen (*Louisville Jour. of Med. and Surg.*, Vol. V.).

The writer publishes two very interesting cases of excision of the rectum for cancer. In each preliminary colostomy was made before the growth was removed by Kraske's method. A deviation was made from the usual operation, in that the lower end of the rectum was inverted and completely occluded, and the perineal wound closed, so that all fecal matter must pass out through the opening in the groin. This obviates having an artificial opening in the sacral region, and the patient does not have to wear a napkin. He says that, if the closure is a success, neither fecal matter nor infected mucous will reach the wound, and primary union will be obtained, which materially lessens danger to life; and further, that the patient will not be bothered with a prolapse of the gut. In one of his cases there was slight leakage and in the other a slight hemorrhage, but both made excellent recoveries. One of them was working at his trade as blacksmith seven months after the operation.

28 East Forty-seventh Street.

THE DRAINAGE CANAL.

BY HAROLD N. MOYER, M.D., Chicago.

THE opening of the drainage canal will take place within a few weeks; not that the canal is finished, but much that still remains to be done can be easily effected after the water has been turned in, and the first link in the great waterway between New Orleans and the great lakes has been established.

An article in the MEDICAL REVIEW, November 25, 1899, from the pen of Hiram Phillips, deals with the subject, and expresses some strong views on what is styled Chicago's great open sewer, by courtesy called the drainage canal. There is much that is just in his criticism of the attitude of Chicago when she organized the drainage district and began the construction of the canal. It would certainly have been wiser if

she had sought the advice of neighboring states and had consulted with towns along the streams which are to receive this immense mass of sewage from Chicago. Possibly there may be some truth in the statement that Chicago's attitude is represented by the words: "We propose to build the drainage canal, and we intend to use it. We are convinced that it will be harmless; we have experts to prove it."

These words are not penned with the idea of maintaining the value of the drainage canal as a sanitary measure. The writer has long since been convinced that the turning of sewage into running streams is a filthy and unsanitary means of disposing of it. The streams and water courses of a state should be efficiently protected against pollutions of this character, and it is a striking coincidence that the year which sees the celebration of the opening of the last great intercepting sewer of Paris, by which the sewage of that city is turned from the waters of the Seine, sees the opening of the drainage canal.

If it could be argued that the Illinois and Mississippi Rivers were quite free from sewage pollution, then the contention that the water of the Chicago River should not be diverted through the new canal into the Illinois River would be sound; but, as a matter of fact, a large proportion of the sewage of this city has been pumped into the smaller canal, which has been in existence for many years. This has been allowed to flow into the Illinois River, polluting the water courses just as effectually, and probably far more so than they will be after the larger canal is opened. Even if the sewage of Chicago should not be turned into these streams, they will still be polluted by the larger towns situated along their banks to such a degree as to make their waters unfit for drinking purposes. The argument, therefore, that the drainage canal should not be opened at this time because it will pollute the waters of the Illinois River is not a valid one, as they already contain an enormous quantity of sewage. The contention which Chicago makes is, that the pouring of a large quantity of fresh water into these channels will decrease the pollution, rendering the streams less offensive and decreasing the danger. Whether this is well founded is by no means established, but it will be difficult to argue that the enormous quantity of fresh water from the lakes will add anything to the danger or offensiveness of these streams. The drainage canal when opened will not add materially to the sum total of sewage now passing into the Illinois River, but will send it forward in a very much less concentrated form.

We hope some day to have the national government take up the subject of the pollution of water courses. When that time arrives, we trust that the laws will exclude the sewage of all towns from rivers or lakes. When it is reached, then Chicago should be compelled to dispose of its sewage in some other way than by allowing it to flow down the Illinois River, and its great drainage canal can be used as a water power and a ship canal, which must ultimately be its chief purpose. There is an injustice, however, in putting burdens upon Chicago that other towns and cities are not called upon to bear. If the large towns situated along the Illinois River are allowed to pour their sewage into its waters, Chicago should be accorded the same privilege. This is one which she now enjoys. The drainage canal is but an amplification and an extension of the principle which has obtained in the disposal of her sewage for more than a quarter of a century. It is simply an enlargement of the old canal and the addition of a large quantity of clean water from the lakes, which shall so dilute this mass of sewage as to render it inoffensive to the eye and nose, if it does not lessen its dangers as a potable water. It is not improbable that the water of St. Louis is polluted and that the prevalence of typhoid fever is due to that cause. There is, however, an entire want of evidence that epidemic diseases will be increased in St. Louis or that the water supply will be more polluted after the large drainage canal is opened.

Notes and Items

"Does Practice Pay?" is the title of an editorial in a recent number of the *Maryland Medical Journal*. It states that the practice of medicine is quite uncertain, and that practice, like money, is unevenly distributed. Those who have much, gain more; those who have little, lose even what they have. Statistics show that of every one hundred graduates after about twenty years a certain proportion have given up medicine. Some succeed and thrive well; many eke out their existence in a miserable way.

George Trebel, in writing to the *Railway Surgeon*, says that the deafness of engineers and firemen, which by some is attributed to the noise of the engine whistle, is not due to that cause. He has examined engineers and firemen, and finds that the latter are deaf in the left ear, while the engineers are deaf in the right. The explanation which he offers is that the fireman in looking out of the cab exposes his left ear to the force of the wind, while the engineer exposes the right. It is this impact of the wind on the ear drum which causes the deafness in the respective ears and not the whistle. The sound of the latter is barely noticeable on an engine while in motion. Engineers and firemen of yard engines are not noticeably deaf, for the reason that the speed of their engines is not great, and as a result the impact of the wind is practically nothing.

The Western Surgical and Gynecological Association will hold its next meeting at Des Moines, Iowa, December 28-29, 1899.

The following is the program of the St. Louis Medical Society of Missouri, Saturday evening, December 9th, 1899: "A Demonstration of Cephalometry," by Dr. C. Shattinger.

Tokelan is the name of a new parasitic disease of the skin which is said to be prevalent in the Malayan Archipelago. It is said to resemble ringworm and herpes circinatus. The disease is said to be due to a fungus which is readily destroyed by chrysarobin.

A Vienna medical student is stated to have surreptitiously obtained a bottle of bacilli from his professor. He then sent a blackmailing letter to an elderly lady of great wealth, stating that unless a specified sum—10,000 florins—was sent to a certain address, the bottle containing bacilli of various infectious diseases would be opened in her room, the effects of which would be almost certainly fatal. The letter was referred to the police, and the medical student instead of receiving the 10,000 florins got eighteen months at hard labor.

The American Committee to have charge of the registration of the Thirteenth International Medical Congress has been organized in Baltimore with Dr. Osler in control. It is composed of presidents of the various societies of specialists of the United States. Dr. H. B. Jacobs, of No. 3 West Franklin street, Baltimore, the secretary of the committee, will receive applications. The fee for "adhesion" is fixed at five dollars. All regular practitioners of medicine are eligible, the blanks merely calling for the name in full, with the address and official position, if any.

The Czar of Russia appears like a man in ill health. He is thin, his complexion is sallow, and it has been more than once stated in the lay journals that he suffers from epileptic seizures. It is said that he was assaulted some years ago while traveling in Japan and that he sustained an injury to the skull. It is now claimed that the skull was trephined at Darmstadt on October 14, in the hope of relieving the cerebral symptoms. Just what truth there may be in this statement it is not possible to say; that there is some foundation for the rumor, is probably true.

On October 14 delegates from the various scientific academies of Europe met at Berlin upon the invitation of the Prussian Academy of Science for the purpose of formulating a universal scientific language. It was proposed to adopt Latin. Whether this effort will prove as abortive as those previously made remains to be seen. The constant agitation of this subject will ultimately lead to the adoption of some language for the purpose of scientific communication. Whether it shall be one of the living or one of the dead languages is by no means certain. If classical tongue is to be adopted, Greek is by all odds the best.

The more frequent meetings of medical societies is brought to our attention by a program of the Maryland Medical and Chirurgical Faculty. It holds semi-annual meetings; the next one is to take place at Westminster. The program is short; the meeting is to be called to order at 10 o'clock, then will follow a historical paper and six other papers, after which there will be an adjournment for luncheon. In the afternoon the scientific business will be resumed, and there will be an adjournment in the evening in time for most of the members to reach home during the evening. This seems to us to be an ideal medical meeting and one which we think might be adopted by our State medical societies. One-day meetings have many advantages. They take the physician away from home but a short time, and the interest for a short meeting will be better maintained than for a lengthy one.

The Philistine occasionally has items of interest to medical men. The last number contains a "Street Car Vignette," by Dr. Frank Lydston. We would especially commend the following as being valuable for neurasthenics, melancholics, and individuals otherwise troubled in their minds:

"THE DON'T WORRY SYNDICATE (Limited).

"Noting the fact that a great many people spend much time in worrying, we have opened a clearing office where our various trained assistants will worry for you while you wait. Ladies who nag are earnestly requested to call. There is no use wearing yourself out in worry and nagging when at a trifling expense you can get the work done. We only employ expert naggers. Send two-cent stamp for samples and testimonials.

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"East Aurora, Erie Co., N. Y."
"Cable address: Ataxia."

Last year Dr. Frederick Peterson offered what was known as the Craig Colony Prize for original research in epilepsy. The amount was $100. The board of award was composed of three members of the New York Neurological Society, and seven papers were submitted, some of which failed to comply with the conditions laid down for the competition and others were more limited in scope. The committee thought that no essay of sufficient merit was received to award the prize. Dr. Peterson has repeated the offer, so that the prize for the year 1900 will be $200, and will be awarded to the writer of the best composition on the pathology and treatment of epilepsy. Originality is the main condition. The manuscripts will again be submitted to three members of the New

York Neurological Society and must be in the hands of Dr. Frederick Peterson, No. 4 West Fiftieth Street, New York, on or before September 1, 1900. The successful essay becomes the property of the Craig Colony, and will be published in its medical report.

The physicians of Elgin, Illinois, are striving to suppress covert newspaper advertising on the part of the profession. It seems that town has been afflicted with a number of physicians who have, under the guise of informing the public of more or less important topics, exploited their own particular capacities as physicians and surgeons. Accordingly they have sent to the local papers the following letter:

"To the Editor: *Sir:*—We, the undersigned members of the medical profession of this city, in deference to certain ethical requirements, as well as to develop a higher *esprit de corps*, do hereby most earnestly request that our names absolutely and in toto be excluded from the columns of your paper in connection with any items or article whatever, excepting under such circumstances as might be of vital interest to the public at large, and then only by permission given in writing over our individual signatures."

The *Philadelphia Times* of November 4th is credited by the *Philadelphia Medical Journal* with a published list, giving the names and dates of those who have died without medical attendance under the ministration of divine healers, and of those who have been made insane and have been sent to asylums. The list is of necessity incomplete, the difficulties of securing accurate figures on the subject being very great. We think that the statistics of Chicago, if they could be accurately gathered, would exceed those of any large city in the country. It seems as if Chicago has been more afflicted with pestiferous charlatans of this character than any city in the country. Cases are almost constantly reported to the coroner. One especially aggravated case was that of a young woman, whose case was the second of four fatal illnesses in a Christian Science household within the last two years. The patient was in good health, was taken with acute appendicitis, and died of general infection and exhaustion on the ninth day of the disease. Autopsy showed that the abscess surrounding the appendix had been perfectly walled off from the general peritoneal cavity; and that if several days preceding her death a simple incision into the abscess had been made, it would have been followed by recovery.

The Narcotic Hospital of St. Louis has opened at Greenville, Texas, a branch hospital. They have appealed to the profession in the following terms: "We have an infallible cure for the morphin, opium, cocain, whisky, and tobacco habits." This is followed by an absolute guarantee of permanent relief and a plea for the names of victims of these habits. In a letter to Dr. Parker of Calvert, Texas, these claims were accompanied by the remarkable statement that in this particular institution they could "cure anything that walks the earth of neurotic habits." We presume that the above was intended to exclude bedridden cases; if so, it reflects a degree of modesty not apparent in the accompanying literature. Dr. Daniel Parker replies through the pages of the *Texas Medical Journal* in the following vigorous language:

"I do not believe that you have any infallible cure for the habits mentioned, and in the second place I should be sorry to know that any unfortunate person had fallen into your hands through any act of mine. If you believe that you have a remedy for any of these thrice-cursed habits, and are withholding a knowledge of it for the sake of profit for yourself, God help those who fall into your hands! If you do not believe what you say when you claim an infallible cure, quit writing to reputable physicians, put your picture and advertisement in the papers, and go into quackery right, like the 'Spermatorrhea,' 'Celery Compound,' 'Fistula,' and 'Peruna' folks. Work in your own class. The physicians of Texas are not going to send any grist to your mill."

"The Necessity for Torch-Light Processions," is the sub-title of an article on the "Rule of Public Opinion," by Thomas B. Reed. He applies it to our political conditions. We quote the following, which is especially applicable to the sciences and to the practice of medicine:

"Every new thought and almost every new discovery which is born into the world, is born into a world which, at the worst, fights it on sight, and at the best is utterly indifferent to it. Its first struggle is to get any attention whatever. It finds mankind adjusted to the old ways and taking notice of nothing else. So far as new things are concerned, the human race is in the condition of the philosophers of Laputa. Flappers are necessary to arouse it to the contemplation of anything outside the use and wont of life. This is true even when the article is vital—when it takes hold of what is dearest of all. We endure filth diseases thousands of years and call them visitations of God, and when some one brighter than the rest discovers the cause and proposes the remedy we listen, in the early ages, with the horror suitable to greet a man who wishes to interfere with God's methods in the universe, and in later times with civil indifference, and go straightway back to our farms and our merchandise. We laugh when we read of the dried bladders filled with beans by which the imaginary inhabitants of the Flying Island were made to give attention, but reflection and observation will show that it takes a great deal of flapping to keep real beings up to their work."

MEDICAL REVIEW

A WEEKLY JOURNAL OF MEDICINE AND SURGERY

EDITED AND CONDUCTED BY

H. W. LOEB, M.D., ST. LOUIS,

AND

WILLARD BARTLETT, M.D.	W. P. LOTH, M.D.
Y. H. BOND, M D.	F. J. LUTZ, M.D.
W. B. DORSETT, M.D.	H. N. MOYER, M.D.
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JAS. G. KIERNAN, M.D.	S. I. SCHWAB, M.D.

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DR. H. W. LOEB, Managing Editor,
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PATIENCE.

When the doctor sees his honest efforts go for naught in the popular success of some new and miraculous method of treating disease, he grows weary of working for the good of his kind. On second thought, however, he will recognize that such aberrations of popular judgment are only natural expressions of the human mind, to be gently dealt with as he would deal with the unattainable longings of a child.

For such popular follies two remedies suggest themselves: Enlightenment of the general public in pathology; general acceptance of scientific medical opinion as oracular. It is difficult to see how either of these remedies could be realized; nor does it seem that either is to be desired. Popular acquaintance with pathology would but increase human suffering by augmenting the growing number of imaginary invalids. Too intimate acquaintance with the possibility of disease would be quite as productive of it, as would absolute ignorance of hygienic laws.

Would blind faith in scientific medicine and the scientific doctor be any better? We think not. Enlightened and progressive as we are proud to say modern medical science is, we should think twice before placing the physician over mankind as an infallible guide in health and disease. It is not for us to wish to arrogate to ourselves the place science forces ignorance to assume. The leader of any popular "ism" of to-day has only installed himself in the niche from which the physician was coaxed by science now some centuries ago. Physicians once were demigods with supernatural powers, depending for success on the vagaries of popular ignorance. To-day their success rests on the broad and everlasting foundation of truth. No, the halo of infallibility is not sought by the scientific physician; he is too well aware of the possibilities of human error.

Let us be patient then with popular medical errors, knowing that founded on ignorance they must ultimately crumble with ignorance, leaving, if there were any, the grains of truth behind, to be incorporated in the great structure of medical truth on which we are all working as modest day laborers.

PHYSIOLOGIC STANDARDIZATION.

Physiologic standardization of drugs will soon come before the Committee on Revision of the Pharmacopeia. If the pharmaceutical and medical press has influence in determining the action of this committee, it is already an assured fact that standardization will be adopted as a basic principle in dealing with drugs. Two able papers have appeared within the last month, and both writers agree upon the general principles of standardization by physiologic testing, but they differ somewhat as to the efficency of the test so far as quantitative reaction is concerned. That is to say, they believe that the physiologic test will show that a given quantity of digitalis, for instance, will produce a certain effect, but it is by no means certain that double the quantity will produce twice the physiologic effect. This last statemeut seems to us to be a misunderstanding of the purpose for which physiologic standardization is undertaken. It is made for the comparing of one preparation of a drug with another preparation of the same drug or different lots of the same drug. It is, in effect, an application of the same principles that govern practitioners in the use of remedies. It is well known that with many drugs which are subject to wide variation, such as cannabis indica, when one has obtained a reliable preparation he clings to it until the supply is exhausted. The experiments were made upon patients, and the drug found to be efficient. All there is in so-called standardization is the urging of the manufacturer to make the necessary tests on animals, and not require us to do it upon our patients.

THE INDICATIONS FOR CHLOROFORM AND ETHER ANESTHESIA.

Some additional light upon this subject has been brought forward by the discussion upon anesthetics by the New York Academy of Medicine:

The experimental researches originally made by THOMSON and KEMP (*New York Med. Journal*, Dec. 2, 1899) seem to demonstrate that ether inhalation can cause in healthy kidneys acute renal suppression as complete as in scarlatinal nephritis. Chronic renal disease, or the presence of any of the systemic signs of renal inadequacy, are contraindications to the use of ether, and if any general anesthetic has then to be employed it should be chloroform. With all its advantages, chloroform cannot be termed a safe anes-

thetic, except in certain functional conditions of the nervous system. It has been administered in hundreds of thousands of cases in military surgery without an accident. Almost the same thing can be said of its administration to women during labor. But given before the heart is excited by the battlefield or by parturition, as when a patient dreads the trivial extraction of a tooth, and it may kill at once. The only condition in ordinary medical practice in which chloroform may be given without uneasiness is when a regular but high-tension pulse is present. In general the contraindications to the use of chloroform furnish indications for the use of ether. Reference is made to the recent improvements in the methods for producing local analgesia, which have been employed in some major operations. With precautions, radical cures of hernia, abdominal laparotomies, etc., have been performed without any suffering by means of local analgesia.

Perhaps in the near future this particular field will be so enlarged that there will be a perfect dovetailing of indications, so that where one form of anesthesia is contraindicated or fraught with danger another can be used with absolute safety.

THE CAMPHOR HABIT.

The *Bulletin of Pharmacy* says that a London physician is authority for the statement that there are many camphor habitues among the young women of the well-to-do classes of that metropolis. He writes: "A notion seems to have got abroad that camphor, taken in small and regular doses, gives a peculiarly clear, creaminess of complexion, and any chemist will tell you that scores of young women buy it for this purpose. But the habit once begun becomes, in many cases, very hard to cast off, for camphor produces a mild form of exhilaration and stupefaction, and I have known many instances, where very large doses have been swallowed, the habit becoming a sort of slavery. These camphor eaters have a very dreamy, dazed, and very listless air, and in most of them there is an ever-present longing to sleep, or at least rest. Extreme weakness generally follows the taking of regular doses; I have seen cases where it has been almost difficult to tell the effect from those of alcohol. As to the complexion, if a ghastly pallor be an improvement, camphor certainly produces it."

Until the above fell under our observation we had no knowledge of addictions to this particular drug. If it were anything like as common as the London physician claims, it would seem that there would have been some reference to it in recent medical literature. Undoubtedly a camphor habit would prove quite as destructive as the alcohol or morphin habits, perhaps even more so, as the drug is certainly a powerful stimulant.

PROGNOSIS IN TYPHOID FEVER.

Typhoid fever furnishes the subject of more communications to medical journals, and is the subject of more medical writing, than any other topic in medical science. Of the long controversies that have been held over the treatment of this disease in the last sixty years, it is only necessary to refer to that dealing with the question of aborting the disease, the antiseptic treatment, the antipyretic treatment, and cold baths.

The pessimists in the therapy of this affection will be very much strengthened by a recent study of Reginald H. Fitts, in the *Boston Medical and Surgical Journal*, November 23, 1899, of the cases of typhoid fever treated in the Massachusetts General Hospital from 1821 to 1898. The number of cases early in this period was small, and it was at this time that typhoid fever was differentiated from other intestinal disorders and other fevers. Modern methods of treatment, so called, were introduced into the hospital about 1840. The whole number of cases treated since that time has amounted to over three thousand. The mortality rate, taking it by decades, is in the neighborhood of fourteen per cent., and while it shows some marked variations from year to year, it is on the whole fairly uniform. The same is true of the complications and relapses. It is stated that the average mortality from this disease is not materially changed from the days of active treatment with emetics, venesection, purgatives, antimony, and calomel, down to the present time.

ANTITOXIC GLOBULINS.

The October 11 meeting of the New York Pathological Society, Mr. James F. Atkinson, the Assistant Chemist in the Research Laboratory of the New York Health Department, presented a communication on the subject of antitoxic globulins. These were obtained from the serum of a horse which had been treated with toxin of diphtheria for the production of the diphtheritic antitoxin serum. He stated that he was able to separate five globulins in the blood by different methods of precipitation. It was found that these substances when separated from the general mass of the blood contained all of the antitoxic properties of the blood. It was proposed to prepare these globulins and use them instead of the blood serum, as it was thought that all or one of them contained the virtues of the antitoxic serum, and consequently they could be used in place of it. In this way it was hoped to obtain the antitoxic serum in a more concentrated form and one which will be devoid of some of the objections to the serum treatment, not the least of which is the very large quantity that must be employed and the extraneous substances which must be injected in order to obtain the probably very minute quantity of antitoxin.

Society Proceedings

ST. LOUIS MEDICAL SOCIETY.

SATURDAY EVENING, OCTOBER 7, 1899, THE PRESIDENT, DR. JOSEPH GRINDON, IN THE CHAIR.

DR. JOHN YOUNG BROWN read a paper on

Some Points in the Pathology of Appendicitis, With Specimens.*

DISCUSSION.

DR. J. K. BAUDUY thought that we need not necessarily and not invariably resort to surgical procedures in all cases of appendicitis. It is wise, however, prudent and conservative for every physician to associate himself with a surgeon when he has the care of a case of appendicitis. Experience teaches us that there are a great many cases of appendicitis which have been shown by post-mortem investigation to have existed and the patients recovered. In fact, it is certain that there are many cases of appendicitis that recover without operation. Of course, appendicitis usually calls for surgical interference, but we may safely wait a few days for the symptoms to become urgent or imminent. In this connection the doctor recalled that he had read a few days ago a very interesting abstract in the REVIEW to the effect that diagnosis of appendicitis was facilitated somewhat by the recognition of the fact that in cases of appendicitis there is invariably an increase in the leucocytes, whereas in some allied cases there is none.

DR. M. J. HOPKINS recommended, when cases are seen early, small doses of morphin, injections of water, "teaspoonful of salt to two quarts," hot as can be borne, into the colon; each injection should be retained about one-half hour. This should be repeated until free evacuation of the bowels takes place. Injection should then be given every four to six hours during the day, for five or six days. Each injection after bowel is cleansed should be retained as long as possible for its happy effect in stimulating leucocytosis, which will take care of the abdominal conditions.

In the meantime, small doses of calomel and veratrum viride should be given to control the blood pressure.

DR. I. N. LOVE called attention to the changes which are taking place in the aspect of the profession towards appendicitis, and stated that he believed the record shows that without surgical interference about 75 per cent. of the cases recover. He endorsed what Dr. Hopkins said when called to case of belly ache—the use of water. As a rule, he administers the injection himself high up into the colon, using a large-size soft rubber catheter or rectal tube. If the pulse points towards an inflammation of the appendix or any other part of the body, it is poor policy to mask that pulse by giving veratrum viride, just as it would be to cover the pain by the administration of morphin. Truly this world would be better if the hypodermic syringe, as it is related to morphin, had never existed. There is one point which should be especially urged, and that is that the physician in a suspected case should make his diagnosis before he leaves the house.

DR. C. M. NICHOLSON: I should feel if I gave opium in appendicitis that I was doing a positive wrong. In fact, I think nothing is indicated until after the diagnosis is made; then there is but one indication—that is to operate. I desire to express the most decided condemnation of the method that suggests the utilization of opium in this connection.

DR. H. M. JOHNSON: I have been struck by the frequency with which the appendix is bound down by a band, and cannot conceive how it could be relieved by any but surgical measures. You have an obstruction to an infected cavity, and it is almost certain to end fatally unless opened up.

DR. R. M. FUNKHOUSER: I believe that the idea that we should operate in every case of appendicitis is radically wrong, though I realize well enough the danger of appendicitis and the danger of two or more attacks. If the inflammatory symptoms subside, I cannot see the necessity for operating at that time. The best time to operate is during the interval between the attacks.

THE PRESIDENT: There are two things which I try to bear in mind in connection with appendicitis: One is that the giving of purgatives is based on a fundamental misconception of the actual condition. No man can tell whether the very first symptoms are not those of perforation. Post-mortems have shown that perforation sometimes accompanies the very first symptoms presented. The other is that the giving of morphin in these cases is a great blunder. While we give our patient ease, we mask the very symptom which might give us information as to the true state of affairs, and may thus lose the golden opportunity on which a life depends.

DR. LOVE: I wish to emphasize particularly the point that the surgeon who does abdominal work should be a specialist in abdominal surgery. He should not be a general practitioner, attending cases of diphtheria, scarlet fever, etc.

DR. JOHN YOUNG BROWN: If we take the pathology of appendicitis into consideration, it is absolutely impossible to tell in any given case what is going on in the appendix either from the pulse or temperature. The specimens that I have presented here to-night fully and conclusively demonstrate this. I have time and time again operated on cases that were apparently mild, though the pathologic lesions present were widespread and dangerous in every particular. With regard to the medical management of these cases, they

*See page 447, this number.

all belong to the domain of surgery. I think this can be substantiated conclusively by the pathology of the conditions and the results that have been obtained by the operative management of the conditions. We have not only in appendicitis a mortality, but we have a morbidity. For instance, there is a tendency in all these cases to retrograde. With early operations and closure without drainage we have an easy, clean-cut convalescence of the patient; he is up and back to his business in from ten to twelve days. The patient is fully restored. On the contrary, if these cases are allowed to go on the possibility is that the surgeon is called to see them at a time when general peritonitis has supervened, and we all know the mortality that follows operations at this time. The most carefully compiled statistics pertaining to this subject will demonstrate conclusively that we have a mortality following the medical treatment of this condition of 25 per cent.; on the other hand, the surgical mortality in the hands of the best men is less than 1 per cent.

A foreign surgeon has put forward the suggestion that appendicitis is caused by the habit of crossing the legs, which restricts the action of the digestive apparatus. The appendix is only loosely attached to the cecum and there is always some half-digested food in the cecal bag. By crossing the legs there is liability that the undigested food may pass into the vermiform appendix and set up an inflammation; in a few hours pathologic processes set in and an attack of appendicitis is developed. The above is taken from a lay journal, and we cannot vouch for the eminence of the "foreign surgeon." It is a decidedly new idea and ought soon to lead to statistics on leg-crossing. Once demonstrated among the laity, it will vastly improve the comfort of street car travel, avoiding the usual hurdle race down the center of the aisle.

There is not a little evidence in the lay and professional journals that the medical and commissary departments of England are woefully inefficient. Already we hear an echo of the charges which were made upon this side of the water at the breaking out of the Spanish-American war. This is the first severe test of the English medical service since the Crimean war. Most of the military operations carried on by the empire of late years have been comparatively small expeditions, which have been adequately handled by the commissary and medical service. From present appearances it would seem that from one hundred to two hundred thousand men would be required in the campaign in the Transvaal. Operating, as it does, a considerable distance from home and in its field service a long distance from the base of supplies, it will be interesting to note whether the superior civil service capacity of the Briton is far ahead of our own.

Current Medical Literature

DERMATOLOGY AND GENITO-URINARY DISEASES.

A Case of Blastomycetic Dermatitis of the Leg.—HEKTOEN* reports a case of this rare affection, with special reference to the histology. Clinically and microscopically the growth resembles carcinoma. The diagnosis is rendered all the more difficult because histologically it resembles on the one hand carcinoma of the skin, on the other tuberculosis. Blastomycosis is characterized microscopically by epithelial proliferation in the form of carcinomatoid masses, formation of embryonal cells, giant cells, diffuse and focal leucocytic infiltration in the form of miliary abscesses, and in these abscesses the presence of double contoured, budding, yeast-like organisms. The so-called blastomycetes have as yet not been definitely classified. Though the blastomycoses resemble in many ways carcinoma, none of the cases described have pursued the clinical course characteristic of cancer. Metastases have not been noted. Carcinoma may originate in the lesions of cutaneons blastomycosis, however.

Report of a Case of Salicylic Acid Dermatitis, with Its History.—M. F. ENGMAN†. The eruption was absolutely symmetrical, and consisted of raised, shiny, smooth, erysipelatously reddened plaques, undergoing involution in the center by slight desquamation and sinking, forming more or less distinct rings. Patches were distributed over the backs of the hands, fingers, wrists, exterior sides of forearms, on the neck, forehead and sides of the face. The conjunctivæ were infected and the lids puffy. The face and extremities were much swollen. The changes observed on histologic examination of a portion excised from the edge of a patch on the wrist were these: 1. Dilatation and engorgement of the vessels, with inflammatory changes in their walls. 2. Edema of the tissue. 3. Hypertrophy of the collagen. 4. Cell infiltration about all the vessels, most marked in the subpapillary region. 5. Formation of densely packed areas of inflammatory cells and intracutaneous abscesses. 6. These abscesses may involve the hair follicles secondarily. 7. Proliferation of connective tissue cells along course of vessels and about inflammatory and abscess areas. 8. Deposit of fibrin in certain localities. 9. Dilatation of lymph spaces of epidermis with edema of epithelial cells. 10. Ballooning of epithelial cells. 11. Necrosis of epithelial cells in areas, with attempt at vesicle formation. 12. Invasion of epidermis by wandering cells. These pathologic conditions explain all the objective symptoms presented.

*Jour. A. M. A., Dec. 2, 1899.

†Jour. Cutan. and G.-U. Dis., December, 1899.

Operative Routes to the Seminal Vesicles.—P. R BOLTON*. The routes by which the seminal vesicles may be reached in operations designed for their removal are practically three in number: the inguinal, perineal, and sacral. The steps of the inguinal operation are as follows: 1. Incision over the original canal parallel with Poupart's ligament to scrotum. 2. Splitting aponeurosis of the external oblique over the canal, separation of vas, and enucleation of testis. 3. Ligation of deep epigastric vessels and incisions of transversalis fascia. 4. Separation of peritoneum from iliac fossa wall and pelvis and bladder along the course of the vas deferens to the ureter. 5. Division of vas; its withdrawal from around the ureter. 6. Separation of vas and vesicle from base of bladder and from prostate, and their removal. The perineal operation is done in the following steps: 1. Curvilinear incision from one tuberosity to the other, about one inch in front of the anus and dividing the insertion of the sphincter ani into the tendinous center of the perineum. 2. Division of anterior fibres of levator ani, exposure of rectum and prostate, and separation of these till the base of the prostate and lower ends of the vesicles are reached. 3. Division of one or both ejaculatory ducts at the base of the prostate by a transverse cut, seizure of the vesicle and its forcible extraction. The steps of the sacral operation are: 1. The Rydygier incision. 2. Displacement of the rectum and exposure of the prostate and base of bladder. 3. Isolation of either or both vasa and vesicles directly under the eye, and their removal. The advantages and disadvantages of each method are cited; the sacral operation is preferred in nearly all cases.

The Value of Urotropin in the Treatment of Certain Forms of Genito-Urinary Diseases.—THOMPSON† prefers urotropin as a urinary sterilizer and antiseptic. He has used it in 67 chronic cases of genito-urinary affections with splendid success. Chronic seminal vesiculitis, periodic or persistent phosphaturia, enlarged prostate, etc., were thus treated with good results. The drug is prompt and reliable in action, non-toxic, and non-irritating if used in moderate doses, viz., 7½ grains 2 to 3 times daily. It passes into the urine unchanged and here gives up formaldehyde, thus rendering the urine strongly antiseptic. The author found its diuretic action very slight; in fact, undeserving of claim to such a virtue.

A Castration; Failure.—E. L. KEYES, JR.,‡ performed castration for hypertrophy of the prostate upon a man sixty-three years old. After one year it was evident that the operation was a complete failure. He concludes: 1. That the prostatic enlargement in this case is chiefly peripheral and has been unaffected by treatment. 2. That the cystitis has grown less severe progressively, and that the operation had no effect upon it. 3. That the irritability has remained about the same, and the slight improvement shown after operation may well have been due to the rest and systematic irrigation of the bladder employed at the hospital. 4. That the operation has been a complete failure. 5. That perineal prostatectomy with probable lithotrity is now indicated, as there were symptoms pointing to the presence of a stone, which was afterward verified by examination.

*Jour. Cutan. and G. U. Dis., Dec., 1899.
†Boston Medical and Surgical Journal, Nov. 16, 1899.
‡Jour. Cutan. and G. U. Dis., December, 1899.

EYE, EAR, NOSE AND THROAT.

The Treatment of Syphilitic Stenosis of the Larynx by Intubation.—EVANS.* Many operative procedures have been devised with the hope of permanently overcoming syphilitic stenosis of the larynx, but at their best they have only proven palliative measures. The best results are gotten through intubation, a harmless and comparatively simple procedure. By this means not only are the disagreeable symptoms, especially the dyspnea, immediately and permanently relieved, but the stricture is dilated, and through pressure the granulation tissue absorbed. At first a tube of small caliber is inserted, followed by larger ones. In acute cases it is not often necessary to wear the tube more than ten days, while in chronic cases, where scar formation and ankyloses have taken place, a longer time is necessary. This method has apparently many advantages over tracheotomy.

The Tonsils as Portals of Infection.—MAYER.† It has been demonstrated by a number of unquestionable authorities that the tonsils are portals of infection. Hodenpyl maintains that this is the case only when the tonsillar epithelium is denuded. De Rochmont mentions the following diseases as following angina occasionally: Albuminuria, erythema urticaria, purpura, erysipela, orchitis, oöphoritis, pleuro-pneumonia, strabismus paraplegia, and osteomyelitis. Rheumatism, endocarditis and pericarditis have often been noted as following tonsillar affections. The same micro-organism has often been demonstrated in the diseased tissues and organs as are found in the tonsils. Since septic infections often occur from these supposably harmless affections of the tonsils, it is quite necessary that therapeutic measures should be taken to prevent them. If seen within 24 hours after the onset and energetically treated, they can be aborted. Morphin and tincture of veratrum viride have been found very efficacious for this purpose. After the angina has subsided, every bit of the tonsillar tissues should be removed with the gouge of Farlow, or the galvano cautery wire guard, of which Loeb's is a clever example.

*Medicine, December, 1899.
†Jour. A. M. A., Dec. 2, 1899.

"Chronic Recurring Membranous Pharyngitis."—McReynolds* reports a case of chronic diphtheria, so-called by Morell Mackenzie. The author suggests the above name, since the bacteriologic investigation of these cases has never revealed the presence of the Loeffler bacillus. The patient in this case is 19 years old and in good health otherwise. Uninfluenced by treatment, a membrane, covering at times the entire pharynx and soft palate, recurs two or three times weekly. Spontaneous exfoliation takes place within two or three days, leaving a perfectly healthy surface. If forcibly removed, it leaves a raw surface, which bleeds readily upon manipulation. The daily ingestion of raw onions, or local applications of strong solutions of iodin or nitrate of silver, will prevent the formation for periods of about two weeks. The disease seems to be in no way related to pharyngomycosis or the transient forms of membranous pharyngitis.

A Case of Hysterical Larynx.—F. E. Hopkins.† A large, rapidly-growing, anemic, nervous girl of 15 years suffered from an attack of pertussis. The whoop in the paroxysms was much more marked than usual, and this increased in intensity, so that in two months the ordinary whoop was replaced by a high-pitched piercing sound produced by strong inspiration with the vocal chords tense. The cough ceased, but the "squeal" remained, and ultimately became both inspiratory and expiratory. Examination revealed no local excuse for such explosions. The case was considered as one of hysteria, though other stigmata were absent. The use of the laryngoscope, a favorable prognosis or the promise of the application of a hot electrode to the base of the tongue caused the paroxysms to cease for a few weeks. The galvano-cautery was then applied to some lymphoid hypertrophy at the base of the tongue, and this was followed by an interval of improvement. General anesthesia was resorted to a number of times to control the seizures. The fluid extract of conium up to fifty minims three times a day was also ineffectual. Finally the patient was intubated, and though the tube was retained less than an hour, the result was a happy one. There was no recurrence and the patient's health greatly improved.

The Cause and Treatment of Recurring Laryngeal Stenosis Following Intubation.—L. Fischer.‡ This condition is primarily caused by forcibly pushing a tube into an edematous or infiltrated mucous membrane. It may be due to using a tube which is too large for the lumen of the larynx. Metallic tubes that have been worn for a long time contain large calcareous deposits, and when removed such a tube the mucous membrane is easily lacerated, and thus ulceration is caused. Every tube must be introduced in the gentlest manner possible; the slightest force exerted will lacerate the tissues. It is a wise rule to remove the tube every three days, and it should be removed at the end of five days to avoid irritation from calcareous deposits. These deposits do not form on rubber tubes. If a tube must be introduced more than twice, the rubber tube should be immersed in a solution of hot gelatin containing 5 to 10 per cent. of powdered alum, and introduced with this covering of alum-gelatin. Beneficial results were also obtained from the use of a 10 per cent. solution of ichthyol and gelatin as a covering for the rubber tube. In the same manner a film consisting of gelatin or paraffin without iodoform europhen and 3 per cent. solution, was applied in several cases with good results.

*Jour. A. M. A., Dec. 2, 1899.
†N. Y. Med. Jour., Dec. 2, 1899.
‡N. Y. Med. Rec., Dec. 2, 1899.

Recurrence of the Tonsil After Excision.—F. E. Hopkins* removed the tonsils and some adenoids from a girl 13 years old; the excision, done under ether, was considered thorough, and examination three weeks later justified this opinion. Four months later the patient suffered from what appeared to be amygdalitis, and the left tonsil was considerably enlarged. One month later this was removed with the guillotine. It seemed like the usual hypertrophied tonsil in form and size. There were, however, cicatrices caused by the earlier operation. Examination showed that the specimen was one of simple hypertrophy. The literature on the subject is briefly given. It is noticeable that few cases are alluded to by laryngologists, and that most of the references are of cases which were published some years ago. It would appear that among the causes of recurrence, aside from imperfect operation, are a tuberculous or specific dyscrasia and an acute inflammation of the stump.

Management of Cases of High Anisometropia.—Jackson† concludes from his observations that: 1, every case must be a subject of careful individual study, and the selection of a lens for the worst eye at first somewhat tentative; 2, in those cases capable of nearly equally acute vision in both eyes, the non-hyperopic, or less myopic eye, should have its correcting lens to fit it for distant vision, and the other eye the lens which will adapt it for vision at about one-third of a meter; 3, in rare cases we must be content with the full correction of the better eye and the adjustment to the other of the lens that will enable it to give most aid in binocular vision; 4, in anisometropia the placing of the lenses closer to the eye lessens the annoyances caused by differences between them, because the nearer the lens is to the eye the less it affects the nodal points of the dioptric system and the size of the retinal image; 5, in rare cases of very high myopia in one eye with the other eye but slightly myopic or hyperopic, the removal of the crystalline lens from the myopic eye would be proper.

*N. Y. Med. Jour., Dec. 2, 1899.
†Jour. A. M. A., Dec. 2, 1899.

GYNECOLOGY AND OBSTETRICS.

A Case of Cerebral Hemorrhage Following Labor.—E. M. LAZARD.* The patient was a woman of 31 years, who had had two previous confinements. Urine was normal in quantity, contained albumin and a few hyaline casts. When labor pains began the patient complained of severe headache; pulse was of good tension. During the night there was a constant slow flow of blood from the slowly dilating os; twenty-four hours after labor pains began a six-months fetus was expelled, there was a considerable flow of blood and patient was somewhat exhausted. While the uterus was being manipulated the patient sank into a semi-conscious stupor, with stertorous breathing. Placenta was hastily extracted and ergot given. She soon sank into a deep stupor, convulsive twitching began in the muscles of the right hand, progressively extended and involved the whole body. The patient remained in a comatose state till she died, four days after labor. During this time a small amount of urine was secreted and once was passed voluntarily; it contained a large amount of albumin. The case was considered one of eclampsia and treated accordingly. Autopsy showed the pia over the left occipital lobe and posterior part of cerebrum to be entirely congested. In the left corpus striatum was a ruptured artery, and clotted blood extended from posterior to anterior part of internal capsule and into lateral ventricle. Two facts are emphasized in this case: 1, the peculiarity of the hemorrhage in a patient with low blood pressure, one that had been bled by the dilating os; and, 2, the tendency of the physician to hastily consider eclamptic all convulsions in childbed.

The Formative Period of Uterine Fibroids.—C. P. MURRAY† gives the following summary of suggestions and conclusions: 1. The possibility of determining definite clinical symptoms which would lead to a recognition of a distinct formative period of uterine fibroids, which might suggest a preventive treatment. 2. That the predisposing causes of race, age (other than that of adult life), or condition count for little, and the elaborate reports which form the bulk of the literature up to the present time are of doubtful value. 3. That chronic inflammatory conditions of the endometrium, uterine parenchyma, and of the ovaries and tubes are most powerful predisposing causes, and that there is a direct relation between the hyperplasia of the uterus and the formation of fibromyomata. 4. That extreme disturbances of the nervous system precede and accompany the formation of uterine fibroids. Insomnia, headaches, and hyperesthesia of the sensory organs are present to a greater degree than is usually found when the concomitant symptoms of the inflammatory condition of the uterus are present. 5. That the evolution of the fibroid from the fibromatous centres when it begins to take on growth is exceedingly rapid, and that it is impossible to tell the age of the growth by its size. The rapid appearance and development are the reasons why so few fibroids are seen and examined in their incipiency. That the size and rapidity of growth of a fibroid depend on its blood supply, which is determined from the beginning by the location of the nidus, and therefore such conditions as pregnancy or the menopanse could have little influence. 6. The possibility of the action of curettage as a predisposing cause for these tumors, on account of the violence done to the blood-vessels, and of hastening their growth, because of concentrating their blood supply. 7. The crystallizing effect of Kieffer's experiments upon the theories in regard to the formation of fibromyomata. He has demonstrated that the blood supply is cut off from the uterine tissue, which then becomes condensed into whorls of fibrillæ, which afterward develop into fibroids, obtaining their blood supply from the surrounding uterine tissue. He has shown that the tumors were composed of an histologic structure in no way differing from the normal uterine tissue, save that which related to the concentric arrangement of fibrillæ. There was no evidence of embryonic tissue or new formation.

Stypticin in Uterine Hemorrhage. — ABEGG.* Stypticin, in grain doses two to three times daily, was found very advantageous in menorrhagia, irregularity of the menstrual period, hemorrhage in labor, and especially in the climacterium. In threatened abortion and in cases of hemorrhage due to large myomata or polypi the remedy proved of little use.

*Phila. Med. Jour., Dec. 2, 1899.
†N. Y. Med. Rec., Dec. 2, 1899.

INTERNAL MEDICINE.

Two Cases of Graves' Disease Successfully Treated as Intestinal Autointoxication.— C. L. MINOR.† The first case was that of a young man, twenty-two years old. The disease had undoubtedly begun as a chlorosis, with marked intestinal symptoms; and as this chlorosis had been immediately followed by the Graves' disease, it was justifiable to ascribe both to the same cause. Strictly regulated diet was ordered, meals were given at regular hours, and for the first month quiet and rest were demanded; the lactate and albuminate of iron were used, together with antifermentative mixtures, chiefly consisting of salol, resorcin, betanaphthol, subgallate of bismuth, with an occasional dose of calomel. Chief reliance, however, was placed upon a modified form of lavage, which was expressively termed "liver washing." The patient lies on the right side, with the hips elevated, and from one quart to one gallon of hot water, at from 100° to 105°, is allowed to flow into the

*Centralblatt für Genakologie, Nov. 4, 1899.
†N. Y. Med. Rec., Dec. 2, 1899.

rectum until the whole colon is full. The water is retained for half an hour, and is then evacuated. In one year the patient was apparently entirely cured; there was only slight prominence of the thyroid left; but all the nervous, ocular, vascular and digestive symptoms had disappeared. The second case, a woman, forty-seven years old, had excessive tea habit, flatulence, and ate at frequent intervals. Treatment similar to that of the first case led to marked improvement.

Strict Milk Diet in Diabetes Mellitis. — WINTERNITZ and STRASSER.* The investigations of the authors brought them to the following conclusions: 1, a strict milk diet will render the urine free from sugar, or decrease the quantity decidedly within a short time, usually within 48 hours; 2, this holds true for the diabetes of youth as well as that occurring in obesity, after injury, shock, etc—cases which did not respond to dietary and Carlsbad treatment responded readily to this; 3, in those cases associated with albuminuria and nephritis the albumen disappeared entirely or was greatly decreased; 4, some cases are completely cured of diabetes by the milk diet, even upon the resumption of mixed diet; 5, upon beginning the milk diet there is at first a loss of weight, then the weight remains stationary, or the patient may even gain. In some cases, after the sugar has disappeared completely from the urine, the ingestion of meat will produce it again. It disappears again upon returning to milk. In returning to the mixed diet, after the "milch-cur" it is questionable if green vegetables and cereals are not preferable to meat.

Endocarditis Due to a Minute Organism, Probably the Bacillus of Influenza.— AUSTIN.† Although many cases of endocarditis accompanying influenza have been described clinically, the specific micro-organism has never been demonstrated in the anatomic lesions. In the three cases reported there were found in the vegetations on the valves short, slender bacilli, with polar staining resembling microscopically the influenza bacillus of Pfeiffer. Unfortunately cultures could not be obtained. The morphology of the bacilli, their staining reactions, difficulty of culture, etc., correspond with the properties of the bacillus influenza.

Can We Diagnosticate Obliteration of the Receptaculum Chyli?—A. H. SMITH.‡ From two cases recorded, and from others cited, it would seem that when with symptoms of disease in or about the stomach we have more rapid emaciation than can be otherwise explained, we are justified in making the diagnosis of probable obliteration of the receptaculum chyli, and that this probability would be increased to a very strong presumption if there are in addition rather copious, pale, semi-fluid passages from the bowels Under such conditions much dependence should not be placed upon fatty substances as articles of diet. Milk, so much relied upon in gastric disorders, will be useful only for the proteids and the sugar which it contains. Albuminous and saccharine or sugar-producing foods must be employed in sufficient quantity to compensate for the loss of the fats.

Report of a Fatal Case of Trichinosis.—W. T. HOWARD, JR.,* reports a case of trichinosis without esinophilia, but with large numbers of eosinophilic cells in the muscle lesions. In this case he has been able to confirm Brown's observation on the presence of eosinophiles in the muscle lesions, but there was no evidence to support the claim that eosinophiles are developed from neutrophilic leucocytes in the muscle lesions. On the contrary, there was proof that polymorphonuclear and mononuclear cells with eosinophilic granulations may have their origin in plasma-cells, and this was apparently their only mode of origin in this case. In acute trichinosis, cells with eosinophilic granulations may be stored (or formed?) in the heart muscle, the peribronchial tissue, and the spleen. The finding of a decided increased number of eosinophiles in the mucosa of the stomach and intestine suggests that they were formed in these localities under the influence of trichina, while the latter were either in the intestinal canal or tissues. This observation points to the intestinal mucosa as at least one of the places in which eosinophiles are formed in the eosinophilia of other forms of helminthiasis (ankylostomiasis, etc.).

Pancreatic Hemorrhage.—ANDERS† reports two cases of pancreatic hemorrhage. In the one carcinoma was the causative factor; in the other, very probably an acute pancreatitis. The etiology of hemorrhages from the pancreas cannot be cleared up in every case. Acute pancreatitis is the pathologic condition most often found in the cases reported in literature. The fixed position of the organ renders it susceptible to injury, and in the so-called idiopathic cases of hemorrhage this factor probably plays a rôle. As in the case of the duodenum, where an overdistended stomach, overloaded colon, and a movable kidney, may produce injury, so it may be in the case of the pancreas. Males more frequently have these hemorrhages than females, occurring usually after the forty-fifth year. Alcoholism seems to play a rôle. The author appends a complete tabulated list of the cases reported and the interesting facts connected with each.

NERVOUS AND MENTAL DISEASES.

Morphinism Among Physicians.—T. D. CROTHERS‡ has obtained a history of 3244 physicians

*Centralblatt für Innere Medicine, Nov. 11, 1999.
†Johns Hopkins Hospital Bulletin, October, 1899.
‡N. Y. Med. Rec., Dec. 2, 1899.

*Phila. Med. Jour., Dec. 2, 1899.
†Jour. A. M. A., Dec. 2, 1899.
‡N. Y. Med. Rec., Nov. 25, 1899.

residing in the Eastern and Middle, and some of the cities of the Western States, of whom 21 per cent. were found using spirits or opium to excess. Six per cent. of this number used opium or morphine persistently. Ten per cent. were using opium or other drugs secretly outside of this number. Over twenty per cent., including this number, used spirits in so-called moderation. In another study of 170 physicians seven per cent. used opium or morphin, and six per cent. were secret drug takers. From the personal observation of a number of city physicians, who have a large acquaintance with medical men, from eight to ten per cent. were found to be either secret or open drug and morphin habitues. Many physicians begin to use spirits, opium and other drugs for functional and transient disturbances, and later contract serious organic disease, the early drug-taking having been a contributing cause. Morphinism among physicians is usually associated with the use of the drug by the needle. Some of the effects of the habit are described and the difficulty of effecting a cure pointed out. The removal of the morphin and the restoration of the functional derangements are simple, with the full control of the patient and his surroundings. The treatment and after-cure require far more skill and tax on our therapeutic resources. The mental effect of remedies and efforts are often more effective than in any other disturbance, and constitute a very important means of treatment. The medical morphinist is dangerous to himself and to others, and should place himself under treatment at once.

SURGERY.

Sudden Death From Pulmonary Embolism.—G. P. BIGGS* reports four cases of sudden death from pulmonary embolism, following injuries or operations in the pelvic region. From a study of these and a number of other cases, the following brief conclusions are drawn: 1. Emboli are usually in the shape of cylinders, a little smaller than the lumen of the vein in which they are found. Such cylinders often become folded upon themselves, as they are forced into the branches of the pulmonary artery. 2. The thrombi formed in veins are chiefly of the red variety, though occasionally they are mixed. They may be quite firm and slightly stratified, though at times to the untrained eye they differ but little from the post-mortem coagula. 3. Once started, thrombi in the veins tend to grow rather rapidly in the direction of the blood current. 4. At the best, thrombi are but loosely attached to the wall of the vein, and may separate completely, leaving no distinct mark to indicate the area of attachment. 5. A long cylindrical thrombus may have but a very small base of attachment to one side of a vein, while the remainder of the thrombus floats free in the blood. This explains the absence of symptoms of veinous obstruction. 6. While infection may sometimes play an important part in the causation of the thrombi, such does not usually appear to be the case. Simple extension of thrombi formed in smaller veins, which were damaged at the time of operation or injury, or by subsequent inflammation, will explain the occurrence of thrombi in the large neighboring veins. Slowness of veinous circulation naturally favors this process.

*N. Y. Med. Jour., Nov. 25, 1899.

A New Buried-Suture Method in Which the Threads Can Be Removed.—STAPLER* begins his article by reviewing the defects of existing methods which have the aforesaid object in view. He mentions rightly that in one the tension of the stitches cannot be properly controlled, or that in another the cords cannot be easily removed; believing at the same time that he has overcome all such defects. His plan of closing a wound in the bladder, for instance, is entirely novel, and upon paper at least looks very neat and feasible. With a straight needle and heavy thread he runs along both sides of the incision and parallel to it. Burying the thread for a distance of half an inch, he then leaves it exposed for an eighth of an inch, and again imbeds it for another half inch. The little loops thus left are drawn together by a lacing thread, and in consequence the edges of the wound are approximated. Stapler gives a totally different method for closing a laparotomy wound, and one for which little of commendation can be said. The tissues are united by threads which pass through the skin into deeper structure, and emerging are tied over little gauze pads. The one serious objection to such a suture is the possibility of infectious material passing along the strand into deeper lying tissues.

Appendicitis.—J. O. CONOR† suggests some simplification of the meaning of the term appendicitis, and directs attention to the expediency of adopting a more uniform treatment. Irrespective of the direct causative factor, it will be readily admitted that appendicitis is a local infective malady which constantly degenerates the appendix, and by perforation not infrequently destroys the life of the individual. Immediate celiotomy is unhesitatingly recommended and has been practiced in sixty cases. By this simple procedure all doubt as to the exact condition present can be eliminated and a rapid cure effected by extirpating both the organ and the disease at the same time. In all cases of appendicitis there is some peritonitis, which may be confined to the serous covering of the appendix or may spread by direct contiguity over a few coils of adjoining bowel; but such extension does not imply general peritoneal infection, and the term "general peritonitis" should not be used in describing such a condition. The method of operation is briefly described; in all cases the appendix is taken

*Centralblätt für Chirurgie, Oct. 14, 1899.

†Phila. Med. Jour., Dec. 2, 1899.

out; intestinal adhesions have been broken down in the face of pus cavities, and fresh infection never yet caused. There is far more danger in leaving a rotten appendix behind than in clearing out existing pus, separating adhesions, and removing the organ.

Cocainization of the Spinal Cord as Done by Bier.—SELDOWITSCH* states that clinical experience has borne out our expectations after experimenting on animals in this direction. The reports of four cases are given, and in each the attempt was highly successful. In the first, after an injection of cocain into the spinal canal, an amputation of the leg was performed, total anesthesia of the extremity persisting for fifty-six minutes. In case No. 2 an amputation lasting thirty minutes was performed, and this with complete absence of pain. For thirty-five minutes complete lack of feeling as high as the navel persisted in a third case. The knee was resected without unusual sensations in No. 4, and this although the operation lasted over an hour. In all these instances a chill and high fever of short duration followed the operation, and in three of them there was headache, vomiting and dizziness.

Bilateral Chronic Interstitial Mastitis Cured by Operation.—MARTIN.† A woman, 38 years of age, experienced intense pains, at times stabbing and lancinating in charaeter, over the sternum and both breasts. The breasts gradually became harder, tender to the touch, but presented no nodules or enlargement of the axillary lymph nodes. After having exhausted all other means of relief, both breasts were amputated —at different times, however. There was immediate and entire relief from pain, and the patient improved steadily. The microscopic examination of sections revealed a chronic interstitial mastitis. Malignancy was not excluded until after the removal of the first breast.

Pancreatic Cysts.—MCARTHUR.‡ Virchow classifies pancreatic cysts according to the nature of their walls. The ranula pancreatica, or retention cysts, are dealt with here. They result from an obstructed outflow of pancreatic juice. This may be due to interstitial pancreatitis, stone in the duct, gall stones in the ampulla of Vater, new growths and trauma. The usual symptoms are colic in the duodenal region, disturbance in digestion, lack of fat digestion, as demonstrated by examination of the falla, and icterus or ileus may be present. Diabetes has also been found in connection with these cases. The treatment depends upon the nature of each individual case. Extirpation and suturing to the abdominal wall both yield good results. The two-step drainage though prolonged, is the least difficult, and guarantees greatest safety to the patient. Two cases are reported in which operation resulted satisfactorily.

*Centralblätt für Chirurgie, Oct. 14, 1899.
†Therapeutic Gazette, Nov. 15, 1899.
‡Jour. Am. Med. Ass'n., Dec. 2, 1899.

X-Rays and Injuries of the Head.—J. RUDIS-JICINSKY* advocates the more extensive use of the X-rays as a means of diagnosis in cases of injury of the head. With its help the local cranial wound may be much better examined than in the usual way. The shadow of bone and the shadow of hematoma are altogether different, and in cases of fracture the plan of treatment can be much better determined after such an examination. In cases of foreign bodies the results of diagnosis are still better obtained. Radiographs are illustrated which show the marked difference in shadow between the bony parts and four lead shot introduced behind the bone. In cases of hematoma, bony growths within the cranial walls, some tumors of the brain between the cranial wall and the clear water, and cases of hydrocephalus, the X-ray will be a good help in diagnosis. The pictures shown prove that the shadows, which are seen most beautifully, correspond exactly with the radiation from the disk of platinum in the Crookes tube. Careful and accurate work and a knowledge of anatomy and pathology are necessary if a correct diagnosis is to be made and an accurate picture produced.

A Method of Draining Biliary Canals.—DEMBOWSKI† maintains that a wound in a gall duct should never be united by primary suture, and gives many good reasons in support of his statement. Technical difficulties in the way are very great, and the danger to the patient in case the suture fails to hold are even greater. Considerable time is required for the performance of such an operation, and the gravity of a prolonged narcosis must in consequence be considered. To simplify drainage of these organs the author suggests a very ingenious instrument which is to be left in place until granulation of the wound is well under way. It consists of a T-shaped tube, the vertical portion being divided longitudinally. Over each extremity of the cross-bar a short rubber catheter is fitted. To place the appliances in position for use in the common duct, one catheter is inserted toward the liver and the other toward the intestine, whereupon the two halves of the vertical portion of the T are joined together and secured by two or three little rings.

Right Inguinal Hernia of the Vermiform Appendix.—PETERSON‡ describes a case of irreducible inguinal hernia, which upon operation presented several interesting and unusual features. The hernial sac was found to contain only the free vermiform appendix. It was irreducible because of adhesions of the head of the cecum to the intestinal ring. The appendix was amputated, the adhesions broken up and the ring closed. There are on record 116 cases of such hernia.

*N. Y. Med Jour., Dec. 2, 1899.
†Centralblätt für Chirurgie, Oct. 7, 1899.
‡Jour. A. M. A., Dec. 2, 1899.

Book Reviews

The Surgical Diseases of the Genito-Urinary Tract, Venereal and Sexual Diseases. A Textbook for Students and Practitioners. By G. FRANK LYDSTON, M.D., Professor of the Surgical Diseases of the Genito-Urinary Organs and Syphiology in the Medical Department of the State University of Illinois; Professor of Criminal Anthropology in the Kent College of Law; Surgeon-in-Chief of the Genito-Urinary Department of the West-Side Dispensary; Fellow of the Chicago Academy of Medicine; Fellow of the American Academy of Political and Social Science; Delegate from the United States to the International Congress for the Prevention of Syphilis and the Venereal Diseases, held at Brussels, Belgium, September 5, 1899, etc. Illustrated with 233 Engravings. $6\frac{1}{2}$x$9\frac{3}{4}$ inches. Pages xvi–1024. Extra Cloth, $5.00 net; Sheep or Half-russia, $5.75 net. The F. A. Davis Co., Publishers, 1914-16 Cherry St., Philadelphia.

The author has succeeded in his endeavor to give a practical survey of the field of genito-urinary and venereal diseases. In addition to presenting much of the accepted and standard teachings, some personal "heresies" are given, thus contributing to the work an individuality which enhances its value to the general practitioner. There are numerous illustrations, which, on the whole, are well executed and assist materially in a thorough understanding of the subject matter.

A Manual of Diseases of the Nose and Throat. By CORNELIUS G. COAKLEY, A.M. M.D., Clinical Professor of Laryngology in the University and Bellevue Hospital Medical College, etc. 1899. Lea Bros. & Co., Philadelphia.

This volume of over 500 pages is exactly what it purports to be—a manual on nose and throat diseases for students and practitioners.

Without attempting to enter too deeply into technical rhinology and laryngology, the author omits no details which general practitioners or even beginners in the specialty require.

The text is quite up-to-date, as manifested, for instance, by the portrayal of the value of supra-renal capsule in obviating hemorrhage during operations.

The illustrations, while not numerous, are effective and well-conceived.

Pelvic Inflammations. By WILLIAM R. PRYOR, M.D. Published by W. B. Saunders, 925 Walnut St., Philadelphia.

This little work presents in 240 pages a well-written survey of the important field of pelvic inflammations and their therapeusis. The author counsels in general an active interference, and illustrates his text with over 100 plates, many colored, which include regional anatomy, operations and instruments, and concludes with some valuable formalæ and useful general information. It will be a valuable addition to a physician's library.

Progressive Medicine. Vol. III. September, 1899. Edited by HOBART AMORY HARE, M.D. Published by Lea Bros. & Co., Philadelphia and New York.

This volume deals with the latest advances of the science of medicine in diseases of the thoracic viscera, skin and nervous system, and in obstetrics. It presents in a succinct form the results of investigations and experiments now interesting the medical world. A physician who desires to keep abreast of the times can hardly afford to be without this volume, which contains 422 pages, with many illustrations and numerous references to the publications in which the articles originally appeared.

Pamphlets Received

Abrupt Onset in Typhoid Fever, by William Pepper, M.D., LL.D., and Alfred Stengel, M.D. (Reprint from *Philadelphia Medical Journal*).

Operations During Pregnancy, by Charles P. Noble, M.D. (Reprint from *American Gynecological and Obstetrical Journal.*)

Circumstances Under Which Chloroform is Preferable to Ether as an Anesthetic, by George W. Gay, A.M., M.D. (Reprint from *Boston Medical and Surgical Journal.*)

A German doctor has devised a plan for massaging rheumatic joints. He takes the patient's hand and puts it in a deep glass which is two-thirds full of quick silver. The mercury exerts an equal pressure on every portion of the fingers, and the pressure increases rapidly as the fingers sink farther into it. The hand is alternately plunged and raised about thirty times at each treatment; after a second treatment there is usually a marked diminution of the swelling.

It is reported that a "celebrated Swiss chemist" has discovered a process by which the human body may be turned to stone. By this means corpses are unchanged in appearance, rendered life-like and non-repulsive. An exchange, in commenting upon this alleged discovery, doubts its authenticity and at the same time bewails its possible consequences. It gives some credit to the Swiss government for taking notice of the discovery and passing a regulation that if it is employed bodies are to be buried. It says: "From a sentimental point of view it has little to recommend it, and on the practical side, what a nuisance such a stone figure would be around the household, especially when house-cleaning time arrives. It would be apt to get chipped and be otherwise mutilated.

Practical Therapeutics.

Further Observations on the Therapeutics of the Chloride of Gold and Sodium.—BROWER and HABHEGGER.* Chloride of gold is recommended as an alterative and tonic. Some fifteen cases are reported, in the majority of which very satisfactory results were observed. Four cases of chlorosis showed improvement in general symptoms, slight improvement in the blood and some increase in elimination. Seven cases of secondary anemia showed splendid results in hemogenesis. In some of these cases the ordinary tonic treatment had failed. Increased elimination was shown in all. A case of chronic tuberculosis was somewhat benefitted.

Heroin in Coughs.—HERWIRSCH† concludes from his observations in some thirty-five cases that heroin is a very valuable remedy in acute and chronic bronchitis and the cough accompanying phthisis. In only three cases was the action unsatisfactory; in one case causing constipation, in another sleep. It is preferable to morphin, since it produces no drug habit, causes no headache or stomach disorder, and the required dose is smaller. This product is cheaper than either morphin or codein.

A Study of Codein and Its Salts.—LOCHBOEHLER.‡ Codein, since its discovery in 1832, has been widely and variously used. It possesses certain advantages over morphin, chief among which is the slight tendency to the creation of the drug habit. The after effects, too, are much better than in the use of morphin. It seems to have a specific sedative action in different forms of cough, such as acute and chronic bronchitis, tuberculosis, etc. In the pains of pelvic and abdominal origin, and in diabetes mellitus, codein has yielded splendid results. The dose is variously stated from ½ grain to 6 grains several times daily. Inasmuch as the drug has no cumulative action, chronic poisoning does not occur from its use. There are, however, a number of cases of acute poisoning reported, all of which resulted in recovery.

Winter Coughs—Grippal Neuroses.—That codeine§ had an especially beneficial effect in cases of nevous cough, and that it was capable of controlling excessive coughing in various lung affections, were noted before its true physiologic action was understood. Later it was clear that its power as a nerve calmative was due, as Bartholow says, to its special action on the pneumogastric nerve. Codeine stands apart from the rest of its group, in that it does not arrest secretion in the respiratory and intestinal tract. In marked contrast is it in this respect to morphin. Morphin dries the mucous membrane of the respiratory tract to such a degree that the condition is often made worse by its use, while its effect on the intestinal tract is to produce constipation. There are none of these disagreeable effects attending the use of codeine. The coal-tar products were found to have great power as analgesics and antipyretics long before experiments in the therapeutic laboratory had been conducted to show their exact action. As a result of this laboratory work we know now that some of them are safe, while others are very dangerous. Antikamnia has stood the test of exhaustive trial, both in clinical and regular practice, and has been proven free from the usual untoward after effects which accompany, characterize and distinguish all other preparations of this class. Therefore antikamnia and codein tablets afford a very desirable mode of exhibiting these two valuable drugs. The proportions are those most frequently indicated in the various neuroses of the larynx, as well as the coughs incident to lung affections, grippal conditions, etc., etc.

Synthetic Chemistry; Its Contributions to Modern Therapeutics.—WAINWRIGHT.* Synthetic chemistry, up to a few decades ago, was nature's specialty, and hers alone. The pharmaceutical chemist has in a measure solved these mysteries, and by virtue of this fact has greatly elevated medicine as a healing science. It is said to have begun in 1828, with Wobler, who produced a substance identical with urea from potassium cyanate and ammonium sulphate. In 1856 mauvein, the first aniline dye, was produced. Then carbolic acid was discovered in coal tar; the coal-tar products resulted, etc. The vegetable alkaloids were supplanted by synthetic products superior to them therapeutically. In these products we have a remedy of a definite chemical and therapeutic action. Antipyretics, hypnotics, uric acid solvents, local anesthetics, antipyretics, tonic albuminoids, etc., etc., have all been produced and advantageously employed in medicine. Pasteur demonstrated the synthetic properties possessed by micro-organism in fermentation. These are known as ptomaines, toxalbumins and toxins, and resemble in their action some vegetable alkaloids. The author urges the encouragement of manufacturing chemists, since they are engaged in a work which can but advance medical science.

For Sale.—A lucrative eye, ear, nose and throat practice in a prosperous western city. Purchaser should be an expert operator and refractionist. Full information on application to

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*Jour. A. M. A., Nov. 25, 1899.
†Therapeutic Gazette, Nov. 15, 1899.
‡Jour. A. M. A., Dec. 2, 1899.
§Laryngoscope.

*Jour. A. M. A., Dec. 2, 1899.